

***Dr. Sheila Harrison-Williams***

 *Superintendent of Schools*

 Authorization for Exchange

 of Confidential Information

Name of Student:

Birth Date:

Address: City Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_is the parent or legal guardian of the above named

 (Print Parent/ Guardian’s Name)

student, I hereby grant permission to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Agency, School District, Individual, etc.

To exchange confidential information concerning my child with: **HAZEL CREST SCHOOL DISTRICT 152 ½ 1910 WEST 170TH ST, Hazel Crest, IL 60429.**

The purpose of the authorization is to procure more information on the student.

I understand that my permission covers the release of permanent and temporary records, as well as the release of confidential records and reports. I also understand that I have the right to inspect and copy school records, to challenge the contents of these records and/or limit this consent to specific records or portions of records which I have designated below.

Health Records \_\_\_\_\_\_\_\_ Student Records \_\_\_\_\_\_\_\_\_ \*Special Ed Records \_\_\_\_\_\_\_\_\_

This authorization terminates 120 calendar days from the date of permission.

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 Date Signature of parent/guardian

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Authorized Personnel Date

**\*Send all Special Education records to Hazel Crest School District 152 ½, 1910 West 170th Street, Hazel Crest, IL 60429. Attn: Office of Special Education**